

Health, Welfare, Public Service
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1-56
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 20 1957

STATE FILE NUMBER

19685

Registration District No.

317

Primary Registration District No.

500

Registrar's No.

1243

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Affton, 23, Mo.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Affton 23</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6520 Lawnside Dr.</u>				Length of stay in lb <u>8 Mo.</u>		d. STREET ADDRESS (If outside, give location) <u>6520 Lawnside Dr.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>E.</u> Last <u>Kraemer</u>				4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 20, 1895</u>	
9. AGE (In years last birthday) <u>61</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		13. FATHER'S NAME <u>Chas. Kyle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u>				16. SOCIAL SECURITY NO. <u>unk.</u>		14. MOTHER'S MAIDEN NAME <u>Jane Norris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u>				17. INFORMANT <u>Affton 23, Mo.</u> <u>Glady's Kraemer 6520 Lawnside Dr.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, multiple</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Hypertensive Cardiovascular Dis.</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>443X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>10 years</u> <u>10 years</u>	
20a. ACCIDENT <input type="checkbox"/>		SUICIDE <input type="checkbox"/>		HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>p. m.</u> Day <u>0</u> Year <u>0</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>Aug 1954</u> to <u>May 1957</u> and last saw <u>her</u> alive on <u>6 May 57</u> Death occurred at <u>9 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Arch M Ahern, M.D.</u>				22b. ADDRESS <u>3915 Watson Road</u>		22c. DATE SIGNED <u>13 May 57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>5-15-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lakewood Park</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
24. FUNERAL DIRECTOR <u>Southern Funeral Home</u> <u>6322 S. Grand Blvd., St. Louis, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>5-14-57</u>		26. REGISTRAR'S SIGNATURE <u>Herkert B. Dink</u>	

(Licensed Embolmer's Statement on Reverse Side)

Kraemer - County

Dr J. J. J. J. J.
Southwestern Med Center
3915 Watson Rd
Om 7-4371
3 to 5 P.M.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by Student Embalmer No.
working under my personal supervision..

Student
Signature of Student Embalmer

Signed David J. J. J. J.

Licensed Embalmer No. 42

P. O. Address S. J. J. J.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.